State of Kansas
Department of Social and Rehabilitation Services
Department on Aging
Kansas Department of Health and Environment,
Division of Health Care Finance

Notice of Final Nursing Facility Medicaid Rates for State Fiscal Year 2013; Methodology for Calculating Final Rates, and Rate Justifications; Response to Written Comments; Notice of Intent to Amend the Medicaid State Plan

Under the Medicaid program, 42 U.S.C. 1396 et seq., the State of Kansas pays nursing facilities, nursing facilities for mental health, and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The Secretary of Aging administers the nursing facility program, which includes hospital long-term care units, and the Secretary of Social and Rehabilitation Services administers the nursing facility for mental health program. Both Secretaries act on behalf of the Kansas Department of Health and Environment Division of Health Care Finance (DHCF), the single state Medicaid agency. As a result of the reorganization of the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services (Executive Reorganization Order No. 41) the nursing facilities program, and the nursing facilities for mental health programwill all be administered under the Kansas Department for Aging and Disability Services after July 1, 2012.

As required by 42 U.S.C. 1396a(a)(13), as amended by Section 4711 of the Balanced Budget Act of 1997, P.L. No. 105-33, 101 Stat. 251, 507-08 (August 5, 1997), the Secretary of the Kansas Department on Aging (KDOA) and the Secretary of the Kansas Department of Social and Rehabilitation Services (SRS) are publishing the final Medicaid per diem rates for Medicaid-certified nursing facilities for State Fiscal Year 2013, the methodology underlying the establishment of the final nursing facility rates, and the justifications for those final rates. SRS and KDOA are also providing notice of the state's intent to submit proposed amendments to the Medicaid State Plan to the U. S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) on or before September 30, 2012.

I. Methodology Used to Calculate Medicaid Per Diem Rates for Nursing Facilities.

In general, the state uses a prospective, cost-based, facility-specific rate-setting methodology to calculate nursing facility Medicaid per diem rates, including the rates listed in this notice. The state's rate-setting methodology is contained primarily in the following described documents and authorities and in the exhibits, attachments, regulations, or other authorities referenced in them:

A. The following portions of the Kansas Medicaid State Plan are maintained by KHPA:

1. Attachment 4.19D, Part I, Subpart C, Exhibit C-1, inclusive;

The text of the portions of the Medicaid State Plan identified above in section IA.1, but not the documents, authorities and the materials incorporated therein by reference, is reprinted in this notice. The Medicaid State Plan provision set out in this notice appears in the version which the state currently intends to submit to CMS on or before September 30, 2012. The proposed Medicaid State Plan amendment that the state ultimately submits to CMS may differ from the version contained in this notice.

Copies of the documents and authorities containing the state's rate-setting methodology are available upon written request. A request for copies will be treated as a request for public records under the Kansas Open Records Act, K.S.A. 45-215 et seq. The state will charge a fee for copies. Written requests for copies should be sent to:

Secretary of Aging
New England Building, Second Floor
503 South Kansas Avenue
Topeka, KS 66603-3404
Fax Number: 785-296-0767

A.1 Attachment 4.19D, Part I, Subpart C, Exhibit C-1: Methods and Standards for Establishing Payment Rates for Nursing Facilities

Under the Medicaid program, the State of Kansas pays nursing facilities (NF), nursing facilities for mental health (NFMH), and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The narrative explanation of the nursing facility reimbursement formula is divided into eleven sections. The sections are: Cost Reports, Rate Determination, Quarterly Case Mix Index Calculation, Resident Days, Inflation Factors, Upper Payment Limits, Quarterly Case Mix Rate Adjustment, Real and Personal Property Fee, Incentive Factors, Rate Effective Date, and Retroactive Rate Adjustments.

1) Cost Reports

The Nursing Facility Financial and Statistical Report (MS2004) is the uniform cost report. It is included in Kansas Administrative Regulation (K.A.R.) 129-10-17. It organizes the commonly incurred business expenses of providers into three reimbursable cost centers (operating, indirect health care, and direct health care). Ownership costs (i.e., mortgage interest, depreciation, lease, and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers' accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Calendar Year End Cost Reports:

All providers that have operated a facility for 12 or more months on December 31 shall file a calendar year cost report. The requirements for filing the calendar year cost report are found in K.A.R. 129-10-17.

When a non-arms length or related party change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the calendar year in which the new operator was not involved in running the facility. The cost report information from the old and new operators shall be combined to prepare a 12-month calendar year end cost report.

Projected Cost Reports:

The filing of projected cost reports are limited to: 1) newly constructed facilities; 2) existing facilities new to the Medicaid program; or 3) a provider re-entering the Medicaid program that has not actively participated or billed services for 24 months or more. The requirements are found in K.A.R. 129-10-17.

2) Rate Determination

Rates for Existing Nursing Facilities

Medicaid rates for Kansas NFs are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base cost data submitted by the provider. The current base cost data is the combined calendar year cost data from each available report submitted by the current provider during 2008, 2009, and 2010.

If the current provider has not submitted a calendar year report between 2008 and 2010, the cost data submitted by the previous provider for that same period will be used as the base cost data. Once the provider completes their first 24 months in the program, their first calendar year cost report will become the provider's base cost data.

The allowable expenses are divided into three cost centers. The cost centers are Operating, Indirect Health Care and Direct Health Care. They are defined in K.A.R. 129-10-18.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days. Before determining the per

diem cost, each year's cost data is adjusted from the midpoint of that year to 12/31/11. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

The inflated allowable historic per diem cost for each cost center is then compared to the cost center upper payment limit. The allowable per diem rate is the lesser of the inflated allowable historic per diem cost in each cost center or the cost center upper payment limit. Each cost center has a separate upper payment limit. If each cost center upper payment limit is exceeded, the allowable per diem rate is the sum of the three cost center upper payment limits. There is also a separate upper payment limit for owner, related party, administrator, and co-administrator compensation. The upper payment limits will be explained in more detail in a separate section.

The case mix of the residents adjusts the Direct Health Care cost center. The reasoning behind a case mix payment system is that the characteristics of the residents in a facility should be considered in determining the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor, the real and personal property fee, and per diem pass-throughs to cover costs not included in the cost report data. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. Pass-throughs are explained in separate subparts of Attachment 4.19D of the State Plan. The add-ons plus the allowable per diem rate equal the total per diem rate.

Rates for New Construction and New Facilities (New Enrollment Status)

The per diem rate for newly constructed nursing facilities, or new facilities to the Kansas Medical Assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 129-10-17.

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to 12/31/11. This adjustment will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket Without Capital Index (IHS Index). The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to 12/31/11. The provider shall remain in new enrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

Rates for Facilities Recognized as a Change of Provider (Change of Provider Status)

The payment rate for the first 24 months of operation shall be based on the base cost data of the previous owner or provider. This base cost data shall include data from each calendar year cost report that was filed by the previous provider from 2008 to 2010. If base cost data is not available the most recent calendar year data for the previous provider shall be used. Beginning with the first day of the 25th month of operation the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider.

All data used to set rates for facilities recognized as a change-of-provider shall be adjusted to 12/31/11. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to 12/31/11. The provider shall remain in change-of-provider status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change of provider status.

Rates for Facilities Re-entering the Program (Reenrollment Status)

The per diem rate for each provider reentering the Medicaid program shall be determined from a projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more. The per diem rate for all other providers reentering the program shall be determined from the base cost data filed with the agency or the most recent cost report filed preceding calendar year 2008.

All cost data used to set rates for facilities reentering the program shall be adjusted to 12/31/11. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to 12/31/11. The provider shall remain in reenrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in reenrollment status.

3) Quarterly Case Mix Index Calculation

Providers are required to submit to the agency the uniform assessment instrument, which is the Minimum Data Set (MDS), for each resident in the facility. The MDS assessments are maintained in a computer database.

The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model is used as the resident classification system to determine all case- mix indices, using data from the MDS submitted by each facility. Standard Version 5.12b case mix indices developed by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) shall be the basis for calculating facility average case mix indices to be used to adjust the Direct Health Care costs in the

determination of upper payment limits and rate calculation. Resident assessments that cannot be classified will be assigned the lowest CMI for the State.

Each resident in the facility on the first day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the first day of each calendar quarter. This RUG-III group shall be translated to the appropriate CMI. From the individual resident case mix indices, three average case mix indices for each Medicaid nursing facility shall be determined four times per year based on the assessment information available on the first day of each calendar quarter.

The facility-wide average CMI is the simple average, carried to four decimal places, of all resident case mix indices. The Medicaid-average CMI is the simple average, carried to four decimal places, of all indices for residents, including those receiving hospice services, where Medicaid is known to be a per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. The private-pay/other average CMI is the simple average, carried to four decimal places, of all indices for residents where neither Medicaid nor Medicare were known to be the per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. Case mix indices for ventilator-dependent residents for whom additional reimbursement has been determined shall be excluded from the average CMI calculations.

The resident listing cut-off for calculating the average CMIs will be the first day of the quarter before the rate is effective. The following are the dates for the resident listings and the quarter in which the average Medicaid CMIs will be used in the quarterly rate-setting process.

Rate Effective Date:	Cut-Off Date:
July 1	April 1
October 1	July 1
January 1	October 1
April 1	January 1

The resident listings will be mailed to providers prior to the dates the quarterly case mix adjusted rates are determined. This will allow the providers time to review the resident listings and make corrections before they are notified of new rates. The cut off schedule may need to be modified in the event accurate resident listings and Medicaid CMI scores cannot be obtained from the MDS database.

4) Resident Days

Facilities with 60 beds or less:

For facilities with 60 beds or less, the allowable historic per diem costs for all cost centers are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data.

Facilities with more than 60 beds:

For facilities with more than 60 beds, the allowable historic per diem costs for the Direct Health Care cost center and for food and utilities in the Indirect Health Care cost center are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data. The allowable historic per diem cost for the Operating and Indirect Health Care Cost Centers less food and utilities is subject to an 85% minimum occupancy rule. For these providers, the greater of the actual resident days for the cost report period(s) used to establish the base cost data or the 85% minimum occupancy based on the number of licensed bed days during the cost report period(s) used to establish the base cost data is used as the total resident days in the rate calculation for the Operating cost center and the Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

There are two exceptions to the 85% minimum occupancy rule for facilities with more than 60 beds. The first is that it does not apply to a provider who is allowed to file a projected cost report for an interim rate. Both the rates determined from the projected cost report and the historic cost report covering the projected cost report period are based on the actual resident days for the period.

The second exception is for the first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous provider's rate, it is also applied when the rate is assigned to the new provider. However, when the new provider files a historic cost report for any part of the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule for the months in the first year of operation. The 85% minimum occupancy rule is then reapplied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

5) Inflation Factors

Inflation will be applied to the allowable reported costs from the calendar year cost report(s) used to determine the base cost data from the midpoint of each cost report period to 12/31/11. The inflation will be based on the IHS index.

The IHS Indices listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment rate period. This may require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment rate period.

The inflation factor will not be applied to the following costs:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

The inflation factor for the real and personal property fees will be based on the IHS index.

6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost center. The upper payment limits are in effect during the payment rate period unless otherwise specified by a State Plan amendment.

Owner/Related Party/Administrator/Co-Administrator Limits:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limits are placed on the amounts reported. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. A standard work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in excess of the Kansas Civil Service based salary chart are transferred to the Operating cost center where the excess is subject to the Owner/Related Party/Administrator/Co-Administrator per diem compensation limit.

The Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2010 historic cost reports in the database from all active nursing facility providers. The salary information in the array is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than 12 months with more than 60 beds. The Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

The Schedule C is used to set the per diem limitation for all non-owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service based salary limitation schedule. The per diem limit for a 50-bed or larger home is set at the 90th percentile on all salaries reported for non-owner administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an administrator of a 15-bed or less facility. The per diem limit for a 15-bed or less facility is inflated based on the State of Kansas annual cost of living allowance for classified employees for the rate period. A linear relationship is then established between the compensation of the administrator of the 15-bed facility and the compensation of the administrator of a 50-bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limits apply to the non-owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the operating cost center.

Real and Personal Property Fee Limit

The property component of the reimbursement methodology consists of the real and personal property fee that is explained in more detail in a later section. The upper payment limit will be 105% of the median determined from a total resident day-weighted array of the property fees in effect April 1, 2011.

Cost Center Upper Payment Limits

The Schedule B computer run is an array of all per diem costs for each of the three cost centers-Operating, Indirect Health Care, and Direct Health Care. The schedule includes a per diem determined from the base cost data from all active nursing facility providers. Projected cost reports are excluded when calculating the limit.

The per diem expenses for the Operating cost center and the Indirect Health Care cost center less food and utilities are subject to the 85% minimum occupancy for facilities over 60 beds. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/administrator/co-administrator limit.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to 12/31/11. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based on the IHS Index.

Certain costs are exempt from the inflation application when setting the upper payment limits. They include owner/related party compensation, interest expense, and real and personal property taxes.

The final results of the Schedule B run are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Operating	110% of the median
Indirect Health Care	115% of the median
Direct Health Care	130% of the median

Direct Health Care Cost Center Limit:

The Kansas reimbursement methodology has a component for a case mix payment adjustment. The Direct Health Care cost center rate component and upper payment limit are adjusted by the facility average CMI.

For the purpose of setting the upper payment limit in the Direct Health Care cost center, the facility cost report period CMI and the statewide average CMI will be calculated. The facility cost report period CMI is the resident day-weighted average of the quarterly facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/20XX-12/31/20XX financial and statistical reporting period would use the facility-wide average case mix indices for quarters beginning 04/01/XX, 07/01/XX, 10/01/XX and 01/01/XY. The statewide average CMI is the resident day-weighted average, carried to four decimal places, of the facility cost report period case mix indices for all Medicaid facilities.

The statewide average CMI and facility cost report period CMI are used to set the upper payment limit for the Direct Health Care cost center. The limit is based on all facilities with a historic cost report in the database. There are three steps in establishing the base upper payment limit.

The first step is to normalize each facility's inflated Direct Health Care costs to the statewide average CMI. This is done by dividing the facility's cost report period CMI by the statewide average CMI for the cost report year, then multiplying this answer by the facility's inflated costs. This step is repeated for each cost report year for which data is included in the base cost data.

The second step is to determine per diem costs and array them to determine the median. The per diem cost is determined by dividing the total of each provider's base direct health care costs by the total days provided during the base cost data period. The median is located using a day-weighted methodology. That is, the median cost is the per diem cost for the facility in the array at which point the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all providers. The facility with the median resident day in the array sets the median inflated direct

health care cost. For example, if there are 8 million resident days, the facility in the array with the 4 millionth day would set the median.

The final step in calculating the base Direct Health Care upper payment limit is to apply the percentage factor to the median cost. For example, if the median cost is $60 and the upper payment limit is based on 120% of the median, then the upper payment limit for the statewide average CMI would be $78 (**D**=130% x $60).

7) Quarterly Case Mix Rate Adjustment

The allowance for the Direct Health Care cost component will be based on the average Medicaid CMI in the facility. The first step in calculating the allowance is to determine the Allowable Direct Health Care Per Diem Cost. This is the lesser of the facility's per diem cost from the base cost data period or the Direct Health Care upper payment limit. Because the direct health care costs were previously adjusted for the statewide average CMI, the Allowable Direct Health Care Per Diem Cost corresponds to the statewide average CMI.

The next step is to determine the Medicaid acuity adjusted allowable Direct Health Care cost. The Medicaid CMI is divided by the statewide average CMI for the cost data period. This answer, is then multiplied by the Allowable Direct Health Care per diem cost. The result is referred to as the Medicaid Acuity Adjustment.

The Medicaid Acuity Adjustment is calculated quarterly to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation: The facility's direct health care per diem cost is $60.00, the Direct Health Care per diem limit is $78.00, and these are both tied to a statewide average CMI of 1.000, and the facility's current Medicaid CMI is 0.9000. Since the per diem costs are less than the limit the Allowable Direct Heath Care Cost is $60.00, and this is matched with the statewide average CMI of 1.0000. To calculate the Medicaid Acuity Adjustment, first divide the Medicaid CMI by the statewide average CMI, then multiply the answer by the Allowable Direct Health Care Cost. In this case that would result in $54.00 (0.9000/1.0000 x $60.00). Because the facility's current Medicaid CMI is less than the statewide average CMI the Medicaid Acuity Adjustment moves the direct health care per diem down proportionally. In contrast, if the Medicaid CMI for the next quarter rose to 1.1000, the Medicaid Acuity Adjustment would be $66.00 (1.1000/1.0000 x $60.00). Again the Medicaid Acuity Adjustment changes the Allowable Direct Health Care Per Diem Cost to match the current Medicaid CMI.

8) Real And Personal Property Fee

The property component of the reimbursement methodology consists of the real and personal property fee (property fee). The property fee is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements. The fee is facility specific and does not change as a result of a change of ownership, change in lease, or with re-enrollment in the Medicaid program. The original

property fee was comprised of two components, a property allowance and a property value factor. The differentiation of fee into these components was eliminated effective July 1, 2002. At that time each facility's fee was re-established based on the sum of the property allowance and value factor.

The property fees in effect on June 1, 2008 were inflated with 12 months of inflation effective July 1, 2008. The inflation factor was from the IHS index. The providers receive the lower of the inflated property fee or the upper payment limit.

For providers re-enrolling in the Kansas Medical Assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the property fee shall be the sum of the last effective property allowance and the last effective value factor for that facility. The property fee will be inflated to 12/31/08 and then compared to the upper payment limit. The property fee will be the lower of the facility-specific inflated property fee or the upper payment limit.

Providers entering the Kansas Medical Assistance program for the first time, who are operating in a building for which a fee has not previously been established, shall have a property fee calculated from the ownership costs reported on the cost report. This fee shall include appropriate components for rent or lease expense, interest expense on real estate mortgage, amortization of leasehold improvements, and depreciation on buildings and equipment. The process for calculating the property fee for providers entering the Kansas Medical Assistance program for the first time is explained in greater detail in (K.A.R. 30-10-25).

There is a provision for changing the property fee. This is for a rebasing when capital expenditure thresholds are met ($25,000 for homes under 51 beds and $50,000 for homes over 50 beds). The original property fee remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in (K.A.R. 129-10-25). The rebased property fee is subject to the upper payment limit.

9) Incentive Factors

An incentive factor will be awarded to both NF and NF-MH providers that meet certain outcome measures criteria. The criteria for NF and NF-MH providers will be determined separately based on arrays of outcome measures for each provider group.

<u>Nursing Facility Quality and Efficiency Incentive Factor:</u>

The Nursing Facility Incentive Factor is a per diem amount determined by six per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a $2.25 per diem add-on. Providers that fall below the 75th percentile staffing ratio but improve their staffing ratio by 10% or more will earn a $0.20 per diem add-on. Providers that achieve a turnover rate at or below the 75th percentile will earn a $2.25 per diem add-on. Providers that have a turnover rate greater than the 75th percentile but that reduce their turnover rate

by 10% or more will receive a per diem add-on of $0.20. Finally, providers that have a Medicaid occupancy percentage of 60% or more will receive a $1.00 per diem add-on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

The table below summarizes the incentive factor outcomes and per diem add-ons:

INCENTIVE OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 75th percentile (4.81), or CMI adjusted staffing < 75th percentile but improved >= 10%	$2.25 $0.20
Staff turnover rate <= 75th percentile, 41% or Staff turnover rate > 75th percentile but reduced >= 10%	$2.25 $0.20
Medicaid occupancy >= 60%	$1.00
Total Incentive Points Available	$5.90

The Culture Change/Person-Centered Care Incentive Program

The Culture Change/Person-Centered Care Incentive Program (PEAK 2.0) includes five different incentive levels to recognize homes that are either pursuing culture change, have made major achievements in the pursuit of culture change, have met minimum competencies in person-centered care, have sustained person-centered care, or are mentoring others in person-centered care.

Each incentive level has a specific pay-for-performance incentive per diem attached to it that homes can earn by meeting defined outcomes. The first two levels are intended to encourage quality improvement for homes that have not yet met the minimum competency requirements for a person-centered care home. Homes can earn both of these incentivies simultaneously as they progress toward the minimum competency level. The third level recognizes those homes that have attained a minimum level of core competency in person-centred care. The fourth and fifth levels are reserved for those homes that have demonstrated sustained person-centered care for multiple years and have gone on to mentor other homes in their pursuit of person-centered care. The table below provides a brief overview of each of the levels.

PEAK Nursing Home Incentive Program

Level	Title	Required Nursing Home Action	State Action	Per Diem Incentive	Incentive Duration

1	**Pursuit of Culture Change**	Completes a person-centered care assessment (KCCI leadership version). Based on evaluation of this information the home then develops and submits an action plan explaining what changes they will implement during the next state fiscal year. The plan must include a time line, a budget, and staff education initiatives. All materials must be submitted in accordance with the PEAK 2.0 application packet.	Reviews assessment documentation and action plan to ensure that PEAK 2.0 application requirements have been met. Implements incentive for the next fiscal year.	$0.50	Available beginning July 1, 2012. Subsequent fiscal year following approved action plan.
2	**Culture Change Achievement**	Submits culture change action plan report to KDOA documenting successful implementation of at least 75% of the core competencies approved. A home can apply for recognition for achievement and pursuit of culture change in the same year.	Reviews culture change action plan report and verifies that it documents at least 75% of the approved core competencies have been met. Conducts site visit to verify that action plan objectives have been met.	$1.00	Available beginning July 1, 2013. Subsequent fiscal year following confirmed successful action plan report.
3	**Person - Centered Care Home**	Completes a person-centered care assessment (KCCI leadership version). Based on evaluation of this information the home then develops and submits a narrative demonstrating that the home has achieved minimum competency in the core areas of PEAK defined person-centered care. Once a home attains this level they are no longer eligible for recognition through levels one and two.	Reviews application to ensure it meets designated criteria. Conducts site visits to confirm application.	$2.00	Available beginning July 1, 2012. Subsequent fiscal year following confirmed minimum competency.
4	**Sustained Person - Centered Care**	Earns person-centered care home award two consecutive years or biennially following initial recognition as sustained person-centered care home. For state fiscal year 2013 only, prevous PEAK award wins will be included. Homes that meet the person-centered care home criteria that have also won a PEAK award once in the previous four years or twice in the first 10 years of PEAK would qualify.	Reviews application to ensure it meets designated criteria. Conducts site visits to confirm application. Reviews prior records to ensure home meets sustained criteria.	$3.00	Available beginning July 1, 2012. Two subsequent fiscal years following confirmation. Renewable biennially.
5	**Person - Centered Care Mentor**	Earns sustained person-centered care achievement award, and successfully mentors another home to earn culture change achievement or Person-Centered Care Home Award. Submits documentation of mentoring activity. For the first year only previous PEAK winners would be allowed to submit evidence of their own mentoring activities and document how that has	Verifies sustained person-centered care achievement award. Reviews mentoring documentation and verifies mentoring activities with mentoree.	$4.00	Available beginning July 1, 2012. Two subsequent fiscal years following confirmation. Renewable biennially.

		led to culture change in other homes.			

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor:

The Quality and Efficiency Incentive plan for Nursing Facilities for Mental Health (NFMH) will be established separately from NF. NFMH serve people who often do not need the NF level of care on a long term basis. There is a desire to provide incentive for NFMH to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

The Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero to three dollars. It is designed to encourage quality care, efficiency and cooperation with discharge planning. The incentive factor is determined by five outcome measures: case-mix adjusted nurse staffing ratio; operating expense; staff turnover rate; staff retention rate; and occupancy rate. Each provider is awarded points based on their outcomes measures and the total points for each provider determine the per diem incentive factor included in the provider's rate calculation.

Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. They will receive two points if their case-mix adjusted staffing ratio equals or exceeds 3.50, which is 120% of the statewide NFMH median of 2.92. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.21, which is 110% of the statewide NFMH median. Providers with staffing ratios below 110% of the NFMH median will receive no points for this incentive measure.

NFMH providers may earn one point for low occupancy outcomes measures. If they have total occupancy less than 90% they will earn a point.

NFMH providers may earn one point for low operating expense outcomes measures. They will earn a point if their per diem operating expenses are below $19.49, or 90% of the statewide median of $21.66.

NFMH providers may earn up to two points for their turnover rate outcome measure. Providers with direct health care staff turnover equal to or below 29%, the 75th percentile statewide, will earn two points as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers with direct health care staff turnover greater than 29% but equal to or below 33%, the 50th percentile

statewide, will earn one point as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs.

Finally, NFMH providers may earn up to two points for their retention rate outcome measure. Providers with staff retention rates at or above 84%, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 77%, the 50th percentile statewide will earn one point.

The table below summarizes the incentive factor outcomes and points:

QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 120% (3.66) of NF-MH median (3.05), or CMI adjusted staffing ratio between 110% (3.36) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $19.14, 90% of NF-MH median, $21.27	1
Staff turnover rate <= 75th percentile, 24% Staff turnover rate <= 50th percentile, 34% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 81% Staff retention >= 50th percentile, 79%	2, or 1
Total Incentive Points Available	8

The Schedule E is an array containing the incentive points awarded to each NFMH provider for each quality and efficiency incentive outcome. The total of these points will be used to determine each provider's incentive factor based on the following table.

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$7.50
Tier 2: 5 points	$5.00
Tier 3: 4 points	$2.50
Tier 4: 0-3 points	$0.00

The survey and certification performance of each NF and NF-MH provider will be reviewed prior to any incentive factor payment. In order to qualify for the incentive factor a home must not have received any health care survey deficiency of scope and severity level "H" or higher during the survey review period. Homes that receive "G" level deficiencies, but no "H" level or higher deficiencies, and that correct the "G" level deficiencies within 30 days of the survey, will receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level "F" will receive 100% of the calculated incentive factor. The survey and certification review

period will be the 15-month period ending one quarter prior to the rate effective date. The following table lists the rate effective dates and corresponding review period end dates.

Rate Effective Date:	Review Period End Date:
July 1	March 31st
October 1	June 30th
January 1	September 30th
April 1	December 31st

10) Rate Effective Date

Rate effective dates are determined in accordance with K.A.R. 30-10-19. The rate may be revised for an add-on reimbursement factor (i.e., rebased property fee), desk review adjustment or field audit adjustment.

11) Retroactive Rate Adjustments

Retroactive adjustments, as in a retrospective system, are made for the following three conditions:

A retroactive rate adjustment and direct cash settlement is made if the agency determines that the base year cost report data used to determine the prospective payment rate was in error. The prospective payment rate period is adjusted for the corrections.

If a projected cost report is approved to determine an interim rate, a settlement is also made after a historic cost report is filed for the same period.

All settlements are subject to upper payment limits. A provider is considered to be in projection status if they are operating on a projected rate and they are subject to the retroactive rate adjustment.

II. Final Medicaid Per Diem Rates for Kansas Nursing Facilities

A. Cost Center Limitations: The state proposes the following cost center limitations which are used in setting rates effective July 1, 2012.

Cost Center	Limit Formula	Per Day Limit
Operating	110% of the Median Cost	$31.45
Indirect Health Care	115% of the Median Cost	$45.89
Direct Health Care	130% of the Median Cost	$99.24
Real and Personal Property Fee	105% of the Median Fee	$9.11

These amounts were determined according to the “Reimbursement Limitations” section.

The Direct Healthcare Limit is calculated based on a CMI of 1.0124, which is the statewide average.

B. Case Mix Index. These proposed rates are based upon each nursing facility's Medicaid average CMI calculated with a cutoff date of April 1, 2012, using the July 1, 2012 Kansas Medicaid/Medikan CMI Table. In Section II.C below, each nursing facility's Medicaid average CMI is listed beside its proposed per diem rate.

C. Proposed Nursing Facility Per Diem Rates and CMI.

The following list includes the calculated Medicaid rate for each nursing facility provider currently enrolled in the Medicaid program and the Medicaid case mix index used to determine each rate.

Facility Name	City	Daily Rate	Medicaid CMI
Village Manor	Abilene	148.27	0.8579
Alma Manor	Alma	159.69	0.8553
Victoria Falls SNF	Andover	184.75	1.1250
Life Care Center of Andover	Andover	150.69	1.1361
Anthony Community Care Center	Anthony	139.10	0.9730
Arkansas City Presbyterian Manor	Arkansas City	162.82	0.9960
Medicalodges Health Care Ctr Arkans	Arkansas City	159.91	1.0358
Arma Care Center	Arma	132.89	1.1138
Ashland Health Center - LTCU	Ashland	167.36	0.8929
Dooley Center	Atchison	161.47	0.7503
Atchison Senior Village	Atchison	157.89	0.9073
Medicalodges Atchison	Atchison	161.34	1.0056
Attica Long Term Care	Attica	163.58	1.0263
Atwood Good Samaritan Center	Atwood	165.13	0.9915
Lake Point Nursing Center	Augusta	141.11	1.0723
Baldwin Care Center	Baldwin City	136.35	1.0550
Quaker Hill Manor	Baxter Springs	122.19	1.0547
Great Plains of Republic County, Inc	Belleville	185.56	1.0200
Belleville Health Care Center	Belleville	133.93	1.1276
Mitchell County Hosptial LTCU	Beloit	178.85	0.9336
Hilltop Lodge Nursing Home	Beloit	151.75	1.0046
Bonner Springs Nursing and Rehabilit	Bonner Springs	143.38	1.0226
Hill Top House	Bucklin	152.76	0.9183
Buhler Sunshine Home, Inc.	Buhler	162.80	0.9017
Life Care Center of Burlington	Burlington	146.69	1.1890
Caney Nursing Center	Caney	102.47	0.8833
Eastridge Nursing Home	Centralia	165.23	0.8700
Applewood Rehabilitation	Chanute	82.25	0.7682
Chanute Health Care Center	Chanute	148.63	1.0234
Heritage Health Care Center	Chanute	130.20	1.0579
Chapman Valley Manor	Chapman	135.06	0.9567
Cheney Golden Age Home Inc.	Cheney	151.30	1.0466
Cherryvale Care Center	Cherryvale	133.95	1.0963
Chetopa Manor	Chetopa	117.14	0.8780

The Shepherd's Center	Cimarron	147.04	1.0177
Medicalodges Clay Center	Clay Center	164.85	0.9141
Clay Center Presbyterian Manor	Clay Center	182.00	0.9858
Clearwater Nursing and Rehabilitation	Clearwater	165.76	1.0300
Community Care, Inc.	Clifton	118.70	0.8800
Park Villa Nursing Home	Clyde	135.54	0.9646
Coffeyville Regional Medical Center	Coffeyville	183.75	1.0079
Windsor Place at Iola, LLC	Coffeyville	150.95	1.0388
Windsor Place	Coffeyville	150.51	1.0644
Medicalodges Coffeyville	Coffeyville	175.30	1.1038
Prairie Senior Living Complex	Colby	174.97	0.9660
Deseret Nursing & Rehab at Colby	Colby	160.03	1.1296
Pioneer Lodge	Coldwater	142.54	0.8686
Medicalodges Columbus	Columbus	163.25	1.0036
Mt Joseph Senior Village, LLC	Concordia	128.37	0.9516
Sunset Home, Inc.	Concordia	152.65	1.0620
Spring View Manor	Conway Springs	114.29	0.8160
Golden Living Center-Chase Co.	Cottonwood Falls	141.78	1.1686
Council Grove Healthcare Center	Council Grove	137.96	1.0442
Hilltop Manor	Cunningham	121.61	0.9697
Derby Health and Rehabilitation	Derby	180.09	1.0459
Westview of Derby	Derby	168.17	1.2790
Hillside Village	DeSoto	141.23	0.9380
Lane County Hospital - LTCU	Dighton	169.52	0.9440
Trinity Manor	Dodge City	146.04	0.9503
Dodge City Good Samaritan Center	Dodge City	147.99	0.9997
Manor of the Plains	Dodge City	163.48	1.0085
Medicalodges Douglass	Douglass	163.80	0.9592
Golden Living Center-Downs	Downs	134.53	0.9878
Country Care Home	Easton	143.36	0.9773
Golden Living Center-Edwardsville	Edwardsville	134.02	0.8526
Golden Living Center-Parkway	Edwardsville	144.76	1.0154
Golden Living Center-Kaw River	Edwardsville	168.71	1.1331
Golden Living Center-El Dorado	El Dorado	133.43	1.0581
Lakepoint Nursing Center-El Dorado	El Dorado	135.71	1.0839
Morton County Hospital	Elkhart	144.79	0.9874
Woodhaven Care Center	Ellinwood	139.76	1.0897
Ellis Good Samaritan Center	Ellis	164.41	1.0655
Good Sam Society-Ellsworth Village	Ellsworth	153.28	1.0461
Flint Hills Care Center, Inc.	Emporia	114.25	0.9649
Holiday Resort	Emporia	134.81	1.0381
Emporia Presbyterian Manor	Emporia	190.26	1.1265
Enterprise Estates Nursing Center, I	Enterprise	129.07	0.9705
Golden Living Center-Eskridge	Eskridge	108.13	0.7685
Medicalodges of Eudora	Eudora	146.85	1.0204
Eureka Nursing Center	Eureka	136.12	1.0238
Kansas Soldiers' Home	Fort Dodge	159.33	0.9332
Fort Scott Manor	Fort Scott	127.54	0.9846
Medicalodges Fort Scott	Fort Scott	156.87	0.9893
Fowler Residential Care	Fowler	156.59	0.8283

Frankfort Community Care Home, Inc.	Frankfort	140.74	1.0100
Golden Living Center-Fredonia	Fredonia	143.44	1.1656
Sunset Manor, Inc	Frontenac	123.58	0.9664
Emerald Pointe Health & Rehab Centre	Galena	119.45	0.8650
Galena Nursing & Rehab Center	Galena	133.73	1.0600
Garden Valley Retirement Village	Garden City	155.78	0.9758
Homestead Health & Rehab	Garden City	161.30	0.9909
Medicalodges Gardner	Gardner	152.02	0.9773
Meadowbrook Rehab Hosp., LTCU	Gardner	196.96	1.1214
Anderson County Hospital	Garnett	172.07	0.8944
Golden Heights Living Center	Garnett	159.34	1.1129
The Heritage	Girard	124.30	1.1105
The Nicol Home, Inc.	Glasco	127.45	0.7920
Medicalodges Goddard	Goddard	175.43	1.0924
Bethesda Home	Goessel	169.79	0.8986
Goodland Sherman Co Good Samaritan	Goodland	154.65	0.9800
Cherry Village Benevolence	Great Bend	134.33	0.8756
Great Bend Health & Rehab Center	Great Bend	139.01	1.0087
Halstead Health and Rehab Center	Halstead	150.05	1.0380
Haviland Care Center	Haviland	97.96	0.8304
St. John's Hays	Hays	152.80	1.0124
St. Johns Victoria	Hays	140.80	0.8567
St. John's of Hays	Hays	147.02	0.9325
Good Samaritan Society-Hays	Hays	140.85	0.9859
Haysville Healthcare Center	Haysville	149.50	0.9506
Medicalodges Herington	Herington	140.49	1.0163
Schowalter Villa	Hesston	183.14	0.9591
Maple Heights of Hiawatha	Hiawatha	123.38	0.9084
Highland Care Center	Highland	140.45	1.1115
Dawson Place, Inc.	Hill City	156.11	0.9394
Salem Home	Hillsboro	164.39	0.9732
Parkside Homes, Inc.	Hillsboro	154.93	1.0263
Medicalodges Jackson County	Holton	145.26	0.9709
Tri County Manor Living Center, Inc.	Horton	113.32	0.9950
Howard Twilight Manor	Howard	142.16	0.9694
Sheridan County Hospital	Hoxie	165.38	1.0070
Pioneer Manor	Hugoton	178.62	0.8904
Golden Plains Rehabilitation Center	Hutchinson	131.29	0.9298
Wesley Towers	Hutchinson	187.50	0.9915
Ray E. Dillon Living Center	Hutchinson	181.11	0.9917
Good Sam Society-Hutchinson Village	Hutchinson	166.35	1.0092
Hutchinson Care Center	Hutchinson	137.91	1.0953
Montgomery Place Nursing Center, LLC	Independence	146.37	1.0107
Regal Estate	Independence	130.19	1.0987
Pleasant View Home	Inman	150.24	0.8480
Iola Nursing Center	Iola	144.42	1.0374
Hodgeman Co Health Center-LTCU	Jetmore	170.13	0.9145
Stanton County Hospital- LTCU	Johnson	172.78	0.8788
Valley View Senior Life	Junction City	154.84	0.9828
Kansas City Presbyterian Manor	Kansas City	182.38	1.0074

Medicalodges Kansas City	Kansas City	169.05	1.0681
Lifecare Center of Kansas City	Kansas City	153.20	1.0829
Medicalodges Post Acute Care Center	Kansas City	174.28	1.1565
Deseret Nursing & Rehab at Kensingto	Kensington	126.88	1.1229
The Wheatlands	Kingman	142.18	0.9984
Medicalodges Kinsley	Kinsley	176.93	0.8989
Kiowa Hospital District Manor	Kiowa	160.68	0.8791
Rush Co. Memorial Hospital	La Crosse	161.19	1.0000
Rush County Nursing Home	Lacrosse	146.52	0.8871
High Plains Retirement Village	Lakin	194.35	1.1200
Golden Living Center-Lansing	Lansing	150.92	1.1312
Larned Healthcare Center	Larned	138.78	0.9784
Pioneer Ridge Retirement Community	Lawrence	156.64	0.9123
Brandon Woods at Alvamar	Lawrence	175.55	0.9396
Lawrence Presbyterian Manor	Lawrence	176.46	1.0108
Medicalodges Leavenworth	Leavenworth	155.41	0.9335
Delmar Gardens of Lenexa	Lenexa	141.37	0.9556
Lakeview Village	Lenexa	188.74	1.0397
Leonardville Nursing Home	Leonardville	123.94	0.9125
Wichita County Health Center	Leoti	145.27	0.6433
Wheatridge Park Care Center	Liberal	153.38	0.9339
Liberal Good Samaritan Center	Liberal	148.38	0.9928
Lincoln Park Manor, Inc.	Lincoln	144.27	1.0223
Bethany Home Association	Lindsborg	180.03	0.9875
Linn Community Nursing Home	Linn	121.85	0.8763
Sandstone Heights	Little River	184.55	1.1150
Logan Manor Community Health Service	Logan	160.73	0.8473
Louisburg Care Center	Louisburg	158.86	1.3618
Good Samaritan Society-Lyons	Lyons	154.12	0.9894
Via Christi Village Manhattan, Inc	Manhattan	151.61	0.9950
Stoneybrook Retirement Community	Manhattan	168.96	1.0568
Meadowlark Hills Retirement Communit	Manhattan	193.40	1.0736
Jewell County Hospital	Mankato	161.98	0.8167
St. Luke Living Center	Marion	144.11	0.8625
Riverview Estates, Inc.	Marquette	154.03	0.9677
Cambridge Place	Marysville	133.17	0.9795
The Cedars, Inc.	Mcpherson	161.90	0.8922
McPherson Care Center	Mcpherson	130.47	1.1607
Meade District Hospital, LTCU	Meade	191.39	1.0507
Trinity Nursing & Rehab Ctr	Merriam	160.72	1.0640
Great Plains of Ottawa County, Inc.	Minneapolis	145.18	1.0079
Good Samaritan Society-Minneapolis	Minneapolis	140.58	0.9793
Minneola District Hospital-LTCU	Minneola	189.07	1.0689
Bethel Home, Inc.	Montezuma	150.92	0.8804
Moran Manor	Moran	132.77	1.2410
Moundridge Manor, Inc.	Moundridge	151.52	0.8695
Pine Village	Moundridge	176.03	1.0328
Mt. Hope Nursing Center	Mt. Hope	133.96	0.8905
Villa Maria, Inc.	Mulvane	140.24	0.9853
Golden Living Center-Neodesha	Neodesha	134.37	1.0818

Ness County Hospital Dist.#2	Ness City	161.90	0.8794
Newton Presbyterian Manor	Newton	176.76	0.9381
Kansas Christian Home	Newton	165.53	1.0133
Asbury Park	Newton	178.89	1.0212
Bethel Care Center	North Newton	160.02	0.9164
Andbe Home, Inc.	Norton	148.81	0.9834
Village Villa	Nortonville	136.54	1.0767
Logan County Manor	Oakley	167.53	0.8457
Good Samaritan Society-Decatur Co.	Oberlin	141.47	0.8545
Decatur County Hospital	Oberlin	159.89	0.8700
Royal Terrace Nrsg. & Rehab. Center	Olathe	137.94	0.9124
Good Samaritan Society-Olathe	Olathe	172.41	0.9522
Aberdeen Village, Inc.	Olathe	185.15	0.9567
Pinnacle Ridge Nursing and Rehabilit	Olathe	143.34	0.9862
Villa St. Francis	Olathe	176.11	1.0564
Evergreen Community of Johnson Count	Olathe	192.16	1.0626
Deseret Nursing & Rehab at Onaga	Onaga	131.19	1.1956
Peterson Health Care, Inc.	Osage City	130.83	1.0405
Osage Nursing & Rehab Center	Osage City	151.93	1.1800
Life Care Center of Osawatomie	Osawatomie	148.28	1.0783
Parkview Care Center	Osborne	133.80	0.9483
Hickory Pointe Care & Rehab Ctr	Oskaloosa	151.01	1.0077
Deseret Nursing & Rehab at Oswego	Oswego	117.42	1.0270
Ottawa Retirement Village	Ottawa	128.91	0.9547
Brookside Manor	Overbrook	134.87	0.9865
Village Shalom, Inc.	Overland Park	187.75	0.9831
Delmar Gardens of Overland Park	Overland Park	171.98	1.0089
Villa Saint Joseph	Overland Park	188.53	1.0379
Garden Terrace at Overland Park	Overland Park	153.74	1.0729
Overland Park Nursing & Rehab	Overland Park	169.96	1.1038
Indian Creek Healthcare Center	Overland Park	171.28	1.1075
Manorcare Hlth Services of Overland	Overland Park	181.76	1.1323
Indian Meadows Healthcare Center	Overland Park	199.27	1.5147
Riverview Manor, Inc.	Oxford	114.09	0.9169
Medicalodges Paola	Paola	114.92	0.6764
North Point Skilled Nursing Center	Paola	142.52	1.0242
Elmhaven East	Parsons	115.93	0.8610
Parsons Presbyterian Manor	Parsons	166.39	0.9852
Elmhaven West	Parsons	134.64	1.0263
Good Samaritan Society-Parsons	Parsons	150.36	1.0605
Westview Manor of Peabody	Peabody	83.83	0.6749
Peabody Care Center, LLC	Peabody	161.02	1.1682
Phillips County Retirement Center	Phillipsburg	133.74	1.0231
Via Christi Village Pittsburg, Inc	Pittsburg	143.35	0.9833
Medicalodges Pittsburg South	Pittsburg	157.37	0.9968
Golden Living Center-Pittsburg	Pittsburg	129.80	1.0319
Rooks County Senior Services, Inc.	Plainville	157.48	0.9010
Pratt Care Center, LLC	Pratt	144.40	1.1259
Pratt Regional Medical Center	Pratt	184.57	1.1365
Prescott Country View Nursing Center	Prescott	124.73	0.9936

Prairie Sunset Manor	Pretty Prairie	143.34	0.7953
Protection Valley Manor	Protection	128.59	0.8770
Gove County Medical Center	Quinter	177.70	0.9500
Grisell Memorial Hosp Dist #1-LTCU	Ransom	168.60	0.9763
Richmond Healthcare and Rehabilitati	Richmond	148.03	1.0229
Lakepoint Nursing Ctr-Rose Hill	Rose Hill	150.91	1.1843
Rossville Healthcare & Rehab Center	Rossville	141.38	1.0902
Russell Regional Hospital	Russell	191.65	1.0456
Wheatland Nursing & Rehab Center	Russell	139.14	1.0473
Apostolic Christian Home	Sabetha	138.12	0.9475
Sabetha Nursing Center	Sabetha	149.67	1.1229
Windsor Estates	Salina	134.04	0.9471
Kenwood View Nursing Center	Salina	131.31	0.9895
Salina Presbyterian Manor	Salina	178.10	0.9955
Pinnacle Park Nursing and Rehabilita	Salina	126.30	1.0385
Holiday Resort of Salina	Salina	152.41	1.0843
Smokey Hill Rehabilitation Center	Salina	138.37	1.0970
Satanta Dist. Hosp. LTCU	Satanta	172.08	0.9281
Park Lane Nursing Home	Scott City	155.92	0.8863
Pleasant Valley Manor	Sedan	116.07	0.9991
Sedgwick Healthcare Center	Sedgwick	161.09	0.9591
Life Care Center of Seneca	Seneca	132.62	1.0400
Crestview Manor	Seneca	117.68	1.0493
Wallace County Community Center	Sharon Springs	151.38	1.0193
Sharon Lane Health Services	Shawnee	138.07	0.9895
Shawnee Gardens Nursing Center	Shawnee	142.00	1.1194
Smith County Memorial Hospital LTCU	Smith Center	171.16	0.8864
Deseret Nursing & Rehab at Smith Ctr	Smith Center	130.37	1.1450
Mennonite Friendship Manor, Inc.	South Hutchinson	177.28	0.9884
Golden Living Center-Spring Hill	Spring Hill	169.07	1.2356
St Francis Good Samaritan Village	St. Francis	159.11	0.9476
Leisure Homestead at St. John	St. John	144.22	0.9238
Community Hospital of Onaga, LTCU	St. Mary's	170.52	0.9205
Prairie Mission Retirement Village	St. Paul	136.53	0.9800
Leisure Homestead at Stafford	Stafford	130.25	0.9557
Sterling Presbyterian Manor	Sterling	170.84	0.8677
Solomon Valley Manor	Stockton	157.32	0.9745
Seasons of Life Living Center	Syracuse	169.62	0.8792
Tonganoxie Nursing Center	Tonganoxie	145.52	1.0242
Brighton Place North	Topeka	89.32	0.6564
Countryside Health Center	Topeka	110.78	0.6907
Providence Living Center	Topeka	93.58	0.7022
IHS of Brighton Place	Topeka	104.47	0.8092
Eventide Convalescent Center, Inc.	Topeka	117.16	0.8402
McCrite Plaza Health Center	Topeka	148.20	0.9189
Topeka Presbyterian Manor Inc.	Topeka	179.01	0.9671
Brewster Health Center	Topeka	182.30	0.9786
Lexington Park Nursing and Post Acut	Topeka	170.77	0.9828
Rolling Hills Health Center	Topeka	170.33	1.0034
Aldersgate Village	Topeka	181.35	1.0217

Plaza West Care Center, Inc.	Topeka	174.36	1.0428
Topeka Community Healthcare Center	Topeka	152.85	1.0719
Manorcare Health Services of Topeka	Topeka	161.85	1.0764
Washburn Community Care Center, LLC	Topeka	158.66	1.0945
Westwood Manor	Topeka	143.50	1.1010
Greeley County Hospital, LTCU	Tribune	173.98	0.9654
The Legacy at Park View	Ulysses	178.98	0.9638
Valley Health Care Center	Valley Falls	133.53	0.7531
Trego Manor	Wakeeney	147.50	0.8942
Trego Co. Lemke Memorial LTCU	Wakeeney	173.46	0.8956
Golden Living Center-Wakefield	Wakefield	153.13	1.0345
Wamego Valley Vista Good Samaritan	Wamego	163.95	1.0170
The Centennial Homestead, Inc.	Washington	127.22	0.9717
Wathena Nursing & Rehab Center	Wathena	148.17	1.0889
Coffey County Hospital	Waverly	164.32	0.8645
Golden Living Center-Wellington	Wellington	126.57	0.9243
Sumner County Care Center	Wellington	132.55	1.1881
Wellsville Manor	Wellsville	131.66	1.0067
Westy Community Care Home	Westmoreland	133.27	0.9976
Wheat State Manor	Whitewater	158.15	0.9500
Via Christi Hope	Wichita	134.41	1.0079
Caritas Center	Wichita	166.59	0.8333
College Hill Nursing and Rehab Cente	Wichita	139.05	0.9033
Golden Living Center-Wichita	Wichita	142.43	0.9347
Meridian Nursing & Rehab Center	Wichita	128.48	0.9616
Homestead Health Center, Inc.	Wichita	170.64	0.9796
Family Health & Rehabilitation Cente	Wichita	163.37	0.9908
Sandpiper Healthcare and Rehab Cente	Wichita	136.69	1.0013
Kansas Masonic Home	Wichita	168.96	1.0015
Catholic Care Center Inc.	Wichita	173.46	1.0045
Lakepoint Nursing and Rehabilitation	Wichita	149.56	1.0190
Medicalodges Wichita	Wichita	163.08	1.0278
Life Care Center of Wichita	Wichita	152.94	1.0894
Seville Care Center, LLC	Wichita	149.31	1.1197
Manorcare Health Services of Wichita	Wichita	163.70	1.1457
Deseret Healthcare and Rehab at Wichita	Wichita	131.73	1.1555
Wichita Presbyterian Manor	Wichita	194.57	1.1650
The Health Care Center@Larksfield Pl	Wichita	180.11	1.2100
Golden Living Center-Wilson	Wilson	145.13	1.1779
Jefferson Co. Memorial Hospital-LTCU	Winchester	166.04	1.0605
Cumbernauld Village, Inc.	Winfield	163.39	0.7888
Kansas Veterans' Home	Winfield	160.85	0.9233
Winfield Rest Haven II LLC	Winfield	163.26	0.9454
Winfield Good Samaritan Center	Winfield	150.70	1.0079
Yates Center Nursing and Rehabilitation	Yates Center	136.24	1.1047

III. Justifications for the Proposed Rates

1. The proposed rates are calculated according to the rate-setting methodology in the Kansas Medicaid State Plan and pending amendments thereto.

2. The proposed rates are calculated according to a methodology which satisfies the requirements of K.S.A. 39-708c(x) and the KHPA regulations in K.A.R. Article 30-10 implementing that statute and applicable federal law.

3. The State's analyses project that the proposed rates:
   a. Would result in payment, in the aggregate of 93.29% of the Medicaid day weighted average inflated allowable nursing facility costs statewide; and
   b. Would result in a maximum allowable rate of $185.69; with the total average allowable cost being $150.47.

c.	Estimated average rate July 1, 2012	$150.47
d.	Average payment rate July 1, 2011	$149.10
	Amount of change	$1.37
	Percent of change	0.91%

4. Estimated annual aggregate expenditures in the Medicaid nursing facility services payment program will increase approximately $4 million.

5. The state estimates that the proposed rates will continue to make quality care and services available under the Medicaid State Plan at least to the extent that care and services are available to the general population in the geographic area. The state's analyses indicate:

   a. Service providers operating a total of 295 nursing facilities (representing 97% of all the licensed nursing facilities in Kansas) participate in the Medicaid program, while an additional 34 hospital-based long-term care units are also certified to participate in the Medicaid program;

   b. There is at least one Medicaid-certified nursing facility and/or nursing facility for mental health, or Medicaid-certified hospital-based long-term care unit in 105 of the 105 counties in Kansas;

   c. The statewide average occupancy rate for nursing facilities participating in Medicaid is 84%;

   d. The statewide average Medicaid occupancy rate for participating facilities is 56.38%; and

   e. The proposed rates would cover 94.93% of the estimated Medicaid direct health care costs incurred by participating nursing facilities statewide.

6. Federal Medicaid regulations at 42 C.F.R. 447.272 impose an aggregate upper payment limit that states may pay for Medicaid nursing facility services. The

state's analysis indicates that the proposed methodology will result in compliance with the federal regulation.

IV. The State's Response to Written Comments on the Published Proposals

The state received three comments to the Notice of Proposed Nursing Facility Medicaid Rates for State Fiscal Year 2012, Methodology for Calculating Proposed Rates, and Rate Justifications; Notice of Intent to Amend the Medicaid State Plan and Request for Comments published in the April 26, 2012 Kansas Register.

V. Notice of Intent to Amend the Medicaid State Plan

The state intends to submit proposed Medicaid State Plan amendments to CMS on or before September 30, 2012.

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